Nazareth Care Charitable Trust

Nazareth House - Cheltenham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 28 and 29 January and 1 February 2016 and was unannounced.

Nazareth House provides care to predominantly older people. Some live with dementia and others have physical needs which they require support with. It can accommodate up to 63 people in total and at the time of the inspection there were 51 people living there. The provider adopts the core values set by the Sisters of Nazareth which are love, justice, hospitality, respect, compassion and patience

A registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager had stopped managing the service in May 2015. Since then another manager had been appointed and had left in December 2015. The current new home manager had started employment with the organisation on 25 January 2016. They had been working in the home for four days when this inspection started. They were an experienced adult social care manager who brought with them various qualifications and skills which would benefit Nazareth House.

People's risks had not always been well managed. This had particularly related to the management of falls where actions to avoid reoccurring falls had not always been taken. Staff were committed to those they looked after but at times were unable to meet people's needs in a way which suited people best. Response times to call bells for example needed to improve. Staff recruitment practices were good and protected people from those who may be unsuitable. People's medicines were administered by staff but some arrangements potentially meant some people were not getting their medicines as prescribed. Improvements to the environment had been made and continued to ne made but not all risks had been addressed. This particularly related to evacuation processes in the event of a fire. People had access to health care professionals when needed. However, confusion in applying the appropriate legislation when people lacked mental capacity meant people's rights were not fully protected. Staff had lacked effective training and adequate support which had resulted in some of the shortfalls identified above. People were supported to eat and drink and potential risks in this area were identified and managed.

People or their representatives had not always been involved in planning and reviewing care; as a result not all care plans were personalised. Care records had not been well maintained but as from November 2015 improvements had started to take place and we saw updated records. This had not caused significant shortfalls in people's care but had meant that staff who did not know people's needs lacked guidance about these. This could potentially lead to inconsistent or unsafe care if not addressed. People had opportunities to partake in social activities but they wanted to be able to go on more trips. Staff worked hard to make the activities enjoyable and meaningful to people. This work was very well supported by volunteers. People had been able to raise complaints and have these taken seriously, investigated and resolved where possible. There had been an increase in complaints during the time of unsettled management but the new home

manager had plans to ensure people could express any areas of dissatisfaction and have these resolved before a complaint was necessary.

The staff at Nazareth House were caring and compassionate. People who mattered to those receiving care were also welcomed and supported. The Sisters of Nazareth Convent provided additional time and pastoral support to anyone of any denomination. This was clearly appreciated by people who lived at Nazareth house and those who visited.

The service had lacked consistent management and staff told us they needed consistent management and a period of stability. The new home manager was aware of the challenges the service presented but had the support of a provider representative to address these and take the service forward. Changes were being made to the provider's quality monitoring systems which would provide a more robust system for identifying and addressing shortfalls. The management team received strong support from the Mother Superior of the Convent. This person brought a wealth of management experience and additional time to guide and counsel the new management team. All were committed to providing a good service and people who used the service were central to achieving this.

We found breaches against four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the overall management of risks to people, the protection of those who lacked mental capacity, a lack of adequate training and support for staff and quality assurance systems which have been unable to drive improvement. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People had not always been protected against risks that may affect them.

Staff were not always available to provide support when people wanted it. Staff wanted to provide personalised care but staffing numbers and how staff were deployed sometimes made this difficult.

Arrangements were in place to address people's pain and end of life medicinal needs.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Is the service effective?

Requires Improvement

The service was not always effective. People's rights were not fully protected because the principles of the Mental Capacity Act (2005) were not always followed.

Staff had not been provided with adequate training or support. New staff had not received consistent support or feedback on their progress when they first started work.

People received support with eating and drinking when this was needed, although the system for recording people's fluid intake could potentially lead to inaccurate records being maintained.

Health care professionals were involved in helping to meet people's physical and mental health needs.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind. Compassion was shown to those receiving care as well as to those that mattered to them.

People's dignity and privacy was maintained at all times.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires Improvement

The service was not always able to be responsive. Care plans sometimes lacked detail and personalisation because the individual they were about, or their representative, were not involved in devising these or reviewing them.

People had opportunities to socialise and partake in activities which staff aimed to make meaningful. People however wanted some improvements in their opportunities to go out on trips.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service had not been well-led and needed a period of continuity in order to re-settle and move forward.
A degree of on-going quality monitoring had continued and some improvement actions had been completed. However, others had not and the service's overall performance needed to improve.

A new and well qualified home manager was already addressing some issues and providing necessary leadership.

The management team were open to people's suggestions and comments in order to improve the service going forward. Issues raised had been incorporated in the provider's improvement plan; they now needed to be addressed.

Nazareth House - Cheltenham

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28, 29 January and 1 February 2016 and was unannounced. It was carried out by one inspector. Prior to our visit we reviewed the information we held about the service. This included statutory notifications which is where the provider tells us about significant events which have taken place. They include: notice of a person's death, concerns relating to the safeguarding of a person from abuse, a serious injury or an event which prevents the smooth running of the service.

When we visited the service we met several people but three were able to tell us about the care and support they received. We spoke with two relatives, 10 members of staff and two visiting health care professionals. We also spoke with one member of staff from a care agency. We reviewed eight people's care records which contained care plans, risk assessments and a daily summary of care provided. We also reviewed a selection of other people's falls risk assessments. We reviewed seven people's medicine administration records. We reviewed three staff recruitment files which included their training certificates and support records.

We also reviewed additional records and documents which related to the management of the service. These included, the service's safeguarding policy and procedures, audits, the provider's improvement plan, accident and incidents records, minutes of resident and relative meetings as well as staff meetings. We reviewed the service's record of complaints and compliments. We reviewed records relating to the maintenance and servicing of various systems and equipment. We also had a tour of the premises and observed a staff hand-over meeting.

Requires Improvement

Is the service safe?

Our findings

People had not always been protected from risks that may have an impact on them. We looked at how risks to people had been identified, managed and monitored. Some shortfalls were related to risks which affected individual people and others related to overall safety at Nazareth House.

The provider had carried out an audit of people's risk assessments and relevant care plans in November 2015. They found these had not been reviewed and kept up to date and staff had been told to address this. The provider re-audited people's risk assessments and care plans in December 2015. Improvements had taken place and staff had started to update these relevant documents. The risk assessments we reviewed had, except in one person's case, been reviewed and updated.

Where people were monitored by health care professionals their risks had been well managed. For example, one person's abilities had altered due to their health condition and potential risks had started to present themselves. Advice had been given by the professional, followed by the staff and specialist equipment supplied. This helped to make the person's everyday life easier and to keep them safe. Another person's decline in health had been monitored by the community nursing team. They had also organised specialised equipment to keep the person comfortable and safe.

Another person's risks had increased over a period of time due to a decline in their health. The person had fallen and after several incidents concerns had been raised by a relative. Their care was reviewed by an external professional. It was found that staff had not identified risks to this person promptly and therefore involving appropriate professionals to help reduce these risks had not been undertaken in a timely way. The involvement by this professional resulted in appropriate equipment being supplied to help keep the person safe. Closer monitoring of their mobility also took place in order to reduce the risk of further falls.

We found when accidents, such as falls, had occurred these had been recorded and first aid and reassurance had been given. However reviewing the person's risk of further accidents/falls had not always taken place. A lack of effective auditing of falls, to include identifying patterns and trends had not protected people from reoccurring falls. In November 2015 the provider's representative set an action for improved auditing to take place. This was not in place at the time of this inspection. The new home manager told us they would be ensuring that auditing arrangements were improved. As part of their day to day checking of systems, processes and practices they would also ensure people were referred to appropriate professionals without delay and that all possible measures had been taken to prevent reoccurring accidents.

People did not always have their needs met in a timely manner. We were aware of calls bells ringing for quite a period of time before they were answered. The new home manager, on several occasions, left her office to investigate why this was the case. She also checked to see if the person ringing the bell was safe. The provider's representative told us they had recently checked the average time it was taking call bells to be answered, which was six minutes. They told us this needed to improve. The new home manager had become aware that only care staff answered people's call bells and when they were busy the calls bells continued to ring. They told us they considered it every member of staffs' responsibility to respond to a call

bell if it continued to ring to ensure the person was safe. They were going to make staff aware of this.

Staff found it hard to personalise some people's care because of the staffing numbers and how staff were deployed. They told us, "Morale (referring to staffs' morale) is very low because of the lack of staff". Comments from staff about the staffing levels and their ability to meet people's needs included, "There are not enough staff upstairs, staff get worn out", "I dread being asked to help out upstairs because it's such hard work", "It's very busy up here, we need additional staff upstairs". However, one comment from a member of staff about the ground floor showed that they felt staff on this floor had time to spend with people. Comments also flagged up how staff worked and used their time. One member of staff said, "Ideally there should be two senior care staff and four care staff on duty (upstairs), quite often there is not and senior care staffs' time is taken up with administering tablets and paperwork". When asking another member of staff about this they said, "It depends who is on duty as to how well the team works".

We witnessed one person on the ground floor get frustrated with waiting for their bath. They had set a time with a member of staff for this who had not turned up to help them. The person had waited 45 minutes and then expressed their frustration to another member of staff about this. An apology was given as well as an explanation which was; the staff were busy at that point and could they wait until later. We were aware that one member of staff had needed to help staff on the first floor. In another situation a member of staff told us they had given a person a bath because they had asked for one and had needed one. They told us it was safe for one member of staff to bathe the person but it was hard work and took a considerable length of time. This was because of the person's complex needs. On this occasion they had gone ahead and helped the person because they had specifically asked for a bath. They explained because of the staffing that morning there were no spare staff to ask for help. There had also been a new agency member of staff who had needed guidance because they did not know people's needs. The member of staff said, "It's very stressful when you have to also support and direct agency staff". They said the home used a lot of agency staff but "They try to get the same ones back because they know what people want".

We discussed staffing numbers and roles with the new home manager and provider's representative. The new home manager confirmed there was an obvious need to review how the home was staffed generally. A dependency tool was in place but we were told this had not been updated. Staff were also not happy with the numbers of staff on duty at night-time and expressed their views about this during the inspection. In particular there were issues between 8pm and 11pm and 6am and 8am. These were times when people wanted help to go to bed or get up and when one member of staff administered medicines. The new home manager responded to these concerns when they were expressed but told us they needed to look at this more closely. At the end of the inspection it was confirmed that night staff numbers would increase by one member of care staff as from immediate effect. A review of the staffing numbers and roles of staff generally was also to take place.

People's medicines were stored safely and the staff who administered medicines had been trained to perform this task. Preparations applied to the skin were recorded on a separate record from the person's medicine administration record (MAR). For some of these the instructions for the frequency of administration differed from that recorded on the person's main MAR. For example, on one person's MAR the instruction from the GP, printed by the Pharmacy, was for the person's cream to be applied four times a day. On the cream record written by the staff the times for application were twice a day and the record only showed this had been applied consistently, once a day. There were other similar examples of this and the member of staff present did not have an explanation for this. There was a risk that people had not therefore had their creams applied as they were prescribed. The new home manager told us they would look at this straight after the inspection.

The National Institute for Clinical Excellence (NICE) guidelines had been followed for paracetamol when prescribed as when required (PRN) (but not for any other medicines prescribed on a PRN basis. This guidance ensures these medicines are used safely and for the correct reasons. Again the new home manager told us she would address this issue.

Staff were aware of who needed regular pain relief and in staff hand over meetings this was discussed. A relative told us how good one member of staff had been in finding out from their relative when they were in pain. Anticipatory end of life medicines were prescribed for one person and in stock. When appropriate and if needed community nurses could visit and administer these easily to keep the person comfortable.

A fire safety officer had visited the home in July 2015 and a fire risk assessment dated July 2015 was in place. High risk actions identified from this visit had been completed. The current fire evacuation plan however related to a full evacuation of the building. We were informed that this needed to be reviewed to include horizontal evacuation which staff had now been trained to perform. Evacuation equipment was seen but we were told staff had not yet received training in its use. Information held in reception for the emergency services, regarding people's different levels of required help in the event of an evacuation, was not up to date. The folder contained information about people who were no longer living at Nazareth House and other people's needs had altered. This put people and others at risk in the event of a fire.

Not all possible actions had been taken to mitigate risks to people. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements for dealing with health related emergencies and injuries had been improved. Five staff had recently completed a first aid course. This course qualified these staff to deliver first aid up until professional (Paramedics) help arrived. The new home manager also forwarded to us the provider's guidance for actions to be taken by staff in a medical emergency or following, for example, a fall. These actions and responsibilities had recently been clarified with the staff.

Some areas of risk were not yet formally monitored by the provider, for example, occurrences of pressure ulcers. The provider's representative explained there was a new Director of Nursing in post and they expected there to be new directives from them on various areas such as this. In the meantime the new home manager told us they would be devising a record to monitor this in house and reporting their findings to the provider's representative.

Appropriate staff recruitment processes helped to protect people from those who may not be suitable. The recruitment files reviewed by us showed that appropriate checks had been carried out before the staff started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had been sought from previous employers and in particular, when past jobs had involved working with vulnerable people. Employment histories had been requested and the reasons for any gaps in this were explored at interview. The new administrator planned to get staff records more organised and this included staff recruitment files.

Staff and the management team understood what their responsibilities were in relation to safeguarding people. Staff knew how to recognise abuse and told us they would report concerns they may have relating to this. Contact numbers for the county council's safeguarding helpdesk were on display in care offices. We had received notifications relating to the safeguarding of people since our last inspection in August 2014. The service had therefore appropriately shared relevant information and investigated issues where

necessary. We were told that staff read the provider's policy and procedures on safeguarding adults during their induction training. Although we were told unexplained bruising or injuries were investigated as part of safeguarding people, we could not always evidence this had been the case when we reviewed people's care records. For example, where a record had been made of bruise, if there was no information about an obvious incident, such as a fall, the record offered no other explanation. Staff were aware of how to whistle blow and report concerns they had relating to poor practice.

People lived in an environment which had been improved and which continued to be improved. For example, extensive refurbishment of the passenger lift had been completed. An annual health and safety audit had been carried by a specialist company on behalf of the provider. An action plan of work to complete had followed and we saw that many of the actions from this had been completed. For example, all window restrictors had been updated and actions to further reduce the risk of Legionella infection were taking place.

Requires Improvement

Is the service effective?

Our findings

People who lived at Nazareth House were, supported to make their own decisions and choices relating to their day to day care and treatment. Care plans recorded people's likes, dislikes and preferences which helped staff support people to make these decisions. One person's care plans referred to the person living with dementia, but also highlighted the fact that they were still able to make certain decisions and choices independently. The care records referred to what decisions this person had made and what choices and preferences were meaningful to the person. However, staff were unclear as to how to apply the appropriate legislation which in some cases left people and staff unprotected.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

After reviewing people's records and not seeing any mental capacity assessments in place, we spoke with a member of staff about the arrangements for protecting those who lacked mental capacity. They told us there had not been any situations where people had needed to make decisions about their care or treatment and they had not been able to do this. They also said people were able to provide consent.

When delivering people's care staff understood that people could not receive care or treatment unless they could provide consent. In order to do this people needed to be able to understand and weigh up the information given to them. Some care records showed that staff supported people to make decisions and be able to give consent by providing them with additional explanations or for example, returning later to provide care when the person was better able to provide consent.

There was however obviously some confusion about when a person's mental capacity should be assessed, when and how to record best interest decisions and when Deprivation of Liberty Safeguards (DoLS) should apply. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In this case there was no evidence of DoLS in place.

For example a person had bed rails in use which would prevent them from getting out of bed on their own and at their choosing. The person was recorded as lacking mental capacity but a capacity assessment had not been completed in relation to the use of bed rails or any other aspect of their care or treatment. There was no consent for the use of the bed rails and no subsequent evidence of best interests having been applied. It was also not clear from people's care records, generally, if consent was provided by people for their care and treatment. In another person's care records the person had been recorded as having capacity and had given consent for the use of bed rails. However, their relative had also been asked to agree to the use of these bed rails. If this person was able to provide their own consent there was no need for their

relative's agreement as well.

People who were presumed to have capacity were able to leave the building when they wanted to independently. One member of staff said, "People are free to leave when they want to". We saw this to be the case during the inspection. The front door was always unlocked during the day-time and only locked later in the day for security reasons. We were told if someone who was known to be confused wanted to go out they were able to do this but with a member of staff to escort them. They explained this would be because they would want to ensure the person returned safely. People therefore would not be able to leave without a degree of control and supervision. We were told there were no people like this asking to go out. However, there were people in Nazareth House, not necessarily requesting to go out but if they attempted to do so a degree of control and supervision would be applied. There had however been no referrals under DoLS to the local authority (the supervisory body) for these people.

When we asked if there were any people living with DoLS authorisations in place, staff thought the previous manager had completed "some" referrals to the local county council (the supervisory body) in relation to this. They were however unsure who this related to or if authorisations had been applied. We contacted the local MCA/DoLS team to establish what referrals had been completed, for whom and to see if any deprivation of liberty authorisations had been sanctioned. The supervisory body had received DoLS referrals for two people but authorisations had not yet been confirmed.

This evidence showed staff were unclear as to how to apply the appropriate legislation and this resulted in some people being unprotected. It also meant that staff providing people's care were not protected under this legislation. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who required better training and better levels of support. Training records showed that most staff had completed training which the provider considered to be necessary to perform their work safely. This included, safeguarding adults, safe moving and handling, infection control, fire safety and the Mental Capacity Act (MCA). However, the lack of knowledge around the MCA/DoLS legislation showed training in this subject had not been effective. Records showed some staff had not completed update training in some subjects for three years. This included safe moving and handling and deprivation of liberty safeguards. One member of staff told us they had not had an update in moving and handling training for over two years and they felt they would benefit from one.

Another member of staff confirmed they had not been provided with supervision for over a year. Supervision is a formal one to one meeting where performance issues and training needs can be discussed. A representative of the provider told us supervision sessions should have been provided every eight weeks. We saw signed supervision agreements saying supervision would be provided "bi-monthly" but were unable to evidence that this had provided. The provider's representative confirmed they had not been able to evidence this either in their auditing. This was also the case for competency checks on staffs' practices. Lengthy gaps between update training and a lack of arrangements for regular staff supervision and the checking of staff competencies put people at risk of receiving care from staff who may not be practicing safely. New staff in their probationary period had also not received a mid-way or end progress evaluation. These sessions were designed to discuss the staff member's progress and identify any support needed.

Effective arrangements had not been made to ensure staff received adequate support, training and supervision to perform their duties safely and thoroughly. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's chosen form of training had historically been the use of DVDs. The new home manager considered this to be inadequate. They told us they would be organising a mixture of face to face training and in house updated training. They aimed to take new staff through the new care certificate and link existing staffs' review of competencies to this. The care certificate sets out the learning competencies and standards of behaviour expected of care workers. The certificate takes new care staff through various modules of training and it then provides a platform for staff competencies to be reviewed on a regular basis. The new home manager had completed the Preparing to Teach in the Lifelong Learning Sector (PTTLS) training at Level 4. This qualified them to identify learning needs, plan for learning, engage learners with differing needs and assess their learning. We were told the provider had committed to an increase in the training budget for the following year 2016/2017. They anticipated this would improve the standard of training provided, for example, by increased use of face to face training.

The new home manager also had good links with people who promoted good dementia care. She had completed the dementia lead training and had previously worked as a dementia lead. She was keen to get the dementia link worker role properly reinstated again when training in the county was available again.

People had access to their GP and community nurses supported staff to meet people's health needs. For example, one person's physical health had deteriorated and community nurses were involved in reducing the possibility of pressure ulcers developing. Another person had regular visits from the community nursing team in relation to the management of their wounds. Other specialist health care professionals including a Parkinson's Disease nurse, diabetes nurse, continence nurse assessor, speech and language therapists and mental health nurses had been consulted and involved appropriately in providing specialist care. People's care records confirmed people had regular access to a Chiropodist and Ophthalmologist (eye assessment/care) and NHS dental care was accessed when needed. A health care professional told us the staff were very good at managing people's behaviours which could be perceived as challenging. In one case this professional had been involved in planning the strategies staff should use to manage this person's distress. These had been implemented effectively and the professional was now going to refer the person back to their GP.

People received support to maintain their nutritional well-being and when risks relating to this presented themselves these were managed. People's weight was monitored and any concerns addressed with the person's GP. Where a person's ability to swallow had caused concern a speech and language therapist had been involved and their advice followed. We observed staff supervising and monitoring people at meals times. Where needed, staff ensured they were aware of what people had eaten. If people needed support to be fed this was done discreetly and the person's dignity maintained.

On the first floor nine people were having their food and drink intake monitored more closely. This meant the actual amount of food and fluid they took in was recorded so their overall intake could be monitored and assessed. During the course of one set of drinks being provided, to approximately 29 people, a member of staff told us they completed the charts later in the shift. When we asked how they remembered what amount each person had drunk they pointed to how much they gave each person and then told us they remembered, in their heads, how much each person had drunk. We were concerned at this practice which potentially led to inaccurate records being kept. We discussed this with the new home manager and they confirmed that staff would from now on establish what each person had actually drunk and recorded the amount straight away to avoid inaccurate record keeping. We observed people had access to drinks at all times.

Good

Is the service caring?

Our findings

One relative compared the care their relative received at Nazareth House with another care home their relative had been in. They said, "The difference here is the staff really care". Another relative told us they felt staff were caring and compassionate. One member of staff also compared Nazareth House favourably with the one they had previously worked in. They said, "It's a really nice atmosphere here. Staff are friendly". We spoke to one person about how the staff were with them, they said "They are lovely".

People were seen as individuals who all had their own life story to tell and had experienced different life events. Staff also saw people's relatives and friends as integral to people's happiness and well-being and they involved them and cared for them also. We reviewed some of the comments made by relatives at the end of their relative's time at Nazareth House. These included: "Thank you for the friendship and care over the last 10 years", "Always treated with care and compassion" and "Staff always willing to lend an ear".

The interactions we observed between people and staff demonstrated that staff genuinely cared for the people they looked after. Their conversations and responses showed they were interested in them and they mattered to them. The Sisters of Nazareth Convent also cared for people from a pastoral perspective but they explained to us that people did not have to be Roman Catholic to receive this or be welcomed in the Chapel. This was explained to people on their admission although, were told that many of the people specifically came to live at Nazareth House because of the access and support with their faith that it provided.

One Sister had been given designated hours by the Convent to provide massages to people. One person had received a hand massage which they told us made a difference to their physical well-being, but they also enjoyed being able to spend one to one time with the Sister. Another Sister carried out daily visits to people at the start and the end of the day. This provided people with time to talk and we witnessed care and compassion being demonstrated and people really appreciating this.

People were actively supported in making choices, which included what they ate and what they did socially. The menu on display offered people a good choice of food with an extensive range of alternatives to the main meal options. We understood however this had not been the case on one of the inspection days and the new home manager was going to investigate what the issue had been following the inspection. They confirmed that a new catering manager had just been recruited and they were confident this scenario would not be repeated.

We saw from people's records there was good communication in place with people's families/representatives, where this was appropriate and where people wished there to be. Both relatives spoken with confirmed staff communicated with them well. One relative in particular told us they were always made to feel welcomed and staff usually brought them a cup of tea during their visit. There were no visiting restrictions in place.

People's privacy and dignity was maintained during delivery of care and generally. People who were able to

and who wished to organise their own health appointments were free to do so. A member of staff told us if people only wished to speak to health care professionals about their health issues then this was respected. There was a designated quiet room which the Sisters of Nazareth had refurbished so people could sit with visitors in private if they chose to do so.

Requires Improvement

Is the service responsive?

Our findings

Two people told us they were "always" looked after well. A third person said, "Oh, it's pretty good here". People's relatives spoke highly of how staff looked after their relatives. One said, "They (staff) are fantastic here. Some are better at handling (name) dementia than others but (name of staff) is particularly excellent". The other said, "The care is excellent".

People's needs were assessed before admission to Nazareth House. This was to ensure staff could meet these. Care plans recorded how people's needs should be met however people and those important to them were not always involved in all aspects of their care planning.

One person's care plans were very personalised recording their specific likes, preferences and choices. The degree of support needed from the staff was very well explained so this gave staff and visiting professionals a very good idea of what care the person required. The care plans also provided good information about what skills and independence the person had retained. The relative of this person told us they had been very involved in devising their relative's care plans and reviewing these to ensure they remained relevant. Feedback from a 'resident' survey carried out by the provider in November 2015 found people wanted to be more involved in this process. Staff confirmed people were spoken with about their needs prior to and on their admission and that these were recorded in some detail within the care plan. However, they confirmed that people and their representatives were not always involved in deciding how these needs would be met or in reviewing the care plans. This was evident as several care plans lacked the personalised detail we saw in the care plan above where their had been involvement of a relative in that case. However where people had lived in the home for a significant length of time long-term staff had got to know this personalised detail which then helped people receive their care in the way they wanted to receive it.

One person's care plan gave staff very little instruction for how to manage the person's behaviour which could be perceived as challenging at times. The care plan described how the person tended to present when distressed but it offered no guidance for staff on how to manage this distress. The plan said to contact the person's GP if the behaviour could not be managed. No details were included about interventions that staff could apply to help distract or relax the person before calling their GP. In this case a specialist health care professional had not been specifically involved in planning strategies to manage this behaviour. Again, permanent staff had learnt through experience in caring for the person the best ways of managing this behaviour but this was not reflected in the care planning. This meant staff who did not know this person well had no guidance. This could potentially lead to inconsistent or unsafe care.

All care records which included care plans were devised and maintained electronically. The provider's representative explained that hard copies of these should also be kept as a backup in case the electronic system could not be accessed. On one floor this had not been done as this had not been communicated to the person maintaining these. An audit in November 2015 found care plans had not been well maintained. Staff had been told to rectify this by the provider. By the time of this inspection most had been reviewed and updated. One member of staff had worked hard to organise this. Staff had varying reasons for the care plans having not been updated, which included: a lack of time to keep the system updated, finding access to the

system difficult and slow due to the broadband speed and connection and generally finding it challenging to use. Although one member of staff said, "I personally like it as it prompts you to complete and update various records". We found the system to be very slow and time consuming when we tried to review people's records and we fed this back to the management team. The provider's representative said they would check to see if the broadband speed could be improved.

We spoke with a member of staff whose role it was to organise and provide social activities. This person had completed specific training to provide activities which were meaningful to people either in groups or on a one to one basis. They told us there were "not enough hours in the day" to do what they would like to do. They complimented what they were able to provide with external entertainers. This involved theatre groups and musicians; a group had just been booked to visit on a regular basis to encourage people to sing together. Activities also had a therapeutic value and one person's anxiety had been reduced when they were kept busy with various social activities. Another person had been supported with one to one relaxation which had helped them relaxed their body; something they found difficult to do because of a medical condition. Another person who lived with dementia regularly joined in arts and crafts based activities and benefited from the social interaction this brought. Planned activities were advertised and a monthly newsletter also alerted people to up and coming events. These were very well supported by volunteers and visiting community groups.

Nazareth House did not have its own form of transport so organising ad hoc outings was difficult if volunteer transport was not available. People then needed to contribute to the cost of the transport. The member of staff said they used taxis to take small groups out for example, to garden centres for tea. They told us a group of people had wanted to go to the theatre last year so the member of staff had organised the transport and escorted them and the people paid for their tickets. Another local care provider lent Nazareth House their transport once a year and a local transport volunteer group were sometimes available to help. Comments in the November 2015 survey and recorded that people wanted more trips out.

A monthly Church of England service took place at Nazareth House and Mass and Vespers took place each day in the chapel attached to the Convent. A resident Roman Catholic Priest led these supported by the Sisters. One Sister told us that between 15 and 20 people attended Mass each morning. The Sisters reminded people and collected them if they needed help to get to the Chapel.

People had been able to raise concerns and complaints, have these taken seriously, investigated and responded to. We looked at complaints recorded from December 2013 to date. These had all been initially acknowledged, investigated and responded to. Some had recorded actions which had been taken to address the issues and some had been resolved by just clarifying things with the complainant. We found there had been an overall increase in complaints received during 2015. This had coincided with changes in the management of the home. The new home manager was keen to resolve people's issues before they became complaints. They told us they would always be available for people to speak with them about areas of dissatisfaction. They told us they were not aware of any unresolved complaints. They also planned to hold formal and informal meeting with people so as to give people opportunities to give feedback and make suggestions on how the service could be improved.

Requires Improvement

Is the service well-led?

Our findings

People and staff at Nazareth House had experienced three different home managers in the last year and in that time the service had not always been well-led. The latest manager had worked in the home for four days when we arrived to carry out this inspection. Staff told us the last six months in particular had been difficult and one relative told us they had expressed concern about this to a provider's representative. They said, "However, the staff just seemed to carry on as usual." One member of staff said, "We just had to get on with things and the staff have done so well". Also during this period of time all the senior staff in the home had altered except two. A new Mother Superior had also arrived in the Convent. They provided a governance and advisory role to the home manager. The new manager told us they had received support from the Mother Superior who brought with them a wealth of management knowledge and experience. The provider's representative, present at the inspection was also new to the organisation in 2015.

What was apparent during the inspection was with a change in so many senior staff/managers had also come changes in management style, expectations, levels of communication and support for the staff. The staff were 'change weary' and made comments about wanting a period of stability and continuity. Staff were however committed to Nazareth House and the people who lived there. The new home manager was an experienced adult social care manager with many years experience. They had worked their way up through the care ranks so had experienced the job from the beginning. They had accumulated several qualifications and skills which would benefit Nazareth House. They had just completed a two week induction to the organisation and since starting work in the home had been faced with issues that they had needed to draw on their experience to manage. The new home manager described herself as "firm but fair". People who had met her told us they liked her and had found her approachable and "easy to talk with." One person said, "She's very visible around the building which is a good thing".

The new home manager had not had time to meet everyone formally but various meetings were planned with different groups of people such as residents and relatives. They had met collectively with some staff and had started to have conversations with others to outline their thoughts and expectations. Their initial goal was to improve the standard of care for people and levels of support for the staff. They had identified quickly that team working and staff morale needed to be re-built. They told us they were aware there were several challenges and issues to address. A meeting had been booked between the new home manager and commissioners of the service so they could meet and contractual requirements could be discussed.

The Mother Superior explained that the home's core values were those of the Sisters of Nazareth which are love, justice, hospitality, respect, compassion and patience. We observed staff upholding these values in their work. The provider's information told us, "people should feel valued and cared for".

The provider's representative had completed monitoring visits and produced a report for the provider. The actions from these were in the process of being shared with the new home manager. The provider's representative was aware that not all audits which should have been completed by senior staff in the home had actually been completed in the last few months. Their view was that the new management team now had to move the home forward. New audits had been introduced by the provider who was introducing set

annual audits with a system of formal checks taking place throughout the year by the home's staff. For example, there would be one annual health and safety audit and one annual infection control audit but a series of in house checks would flag up any shortfalls which would then be addressed. The progress of these checks and subsequent actions would be the responsibility of the home manager and would be checked during the provider's quality monitoring visits. The provider's representative would sign actions off as they were verified as completed.

Running alongside these would be any actions which the provider wanted met which would be in the home's main improvement plan managed by the provider's representative. The provider's representative told us that some of the checks would be altered to make them more appropriate for the service as they started to be used. It was evident that this would need to happen when we were shown one of the first completed care record checks. For example, the audit tool did not prompt the checker to ensure that all care assessments and risk assessments cross referenced with each other and other care plans. This is necessary for the care records to work effectively and for the time being the provider's representative had completed this in their auditing. The new home manager told us they would be doing this automatically as part of their auditing process.

People's views on the services provided were last sought in Nov 2015. Areas for improvement included: reinstate the key worker system (a key worker is a member of the care staff who is designated to a particular person. They are a known point of contact for the person and their family), care plans not reviewed with people or their representatives, lack of sufficient staff and too many staff changes, more trips out and better food choices. The on-going improvement plan had incorporated actions to address these. These issues had not started to be addressed yet apart from the staffing ones.

The current quality assurance processes were not effective at identifying shortfalls in the service as identified in this inspection. Evidence for how feedback was acted upon to evaluate and drive improvements was also not in evidence at the time of inspection. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspection however was received by the management team as a positive experience and an opportunity to review levels of compliance and see where improvements were required. They were aware of the challenges they faced and the risks which needed to be prioritised. They were also aware that some systems, processes and practices needed to become re-established and then maintained. Although it was very early days the new home manager was communicating well with the staff. There was a collective commitment to improve the services provided. A period of continuity was now required for this to be achieved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked mental capacity to make an informed decision or to provide consent staff had not always acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people receiving care and treatment had not been fully assessed and action taken to reduce and/or mitigate those risks. Regulation 12 (2) (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring arrangements were not always effectively maintained in such a manner to successfully assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate risks relating to health, safety and welfare of those who use the service. Regulation 17 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Staff employed by the provider had not received adequate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they needed to perform. Regulation 18 (2) (a)